One Health Quality CTO, LLC MDCTO-0079

Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information			
Application ID Number	MDCTO-0079		
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.		
Organization Site Name	One Health Quality CTO		
DBA Name	One Health Quality CTO, LLC		
Website (if applicable)			
Ownership & Legal Structure			
Owned by Health Care Organization	Yes		
Name of Parent Organization	Adventist HealthCare		
Legal Structure	A single member not-for-profit limited liability company based in MT county		
Service Area			
Counties Served	Montgomery County		
Partnerships			
Formal Partnerships	Nexus Montgomery and Healthy Montgomery (LHIC)		
Informal Partnerships			
Services Offered			
Tele-diagnosis	Currently in place		
Tele-behavioral health	Currently in place		
Tele-consultation	Planned for future		
Remote Monitoring	Currently in place		
Other			
HIT			
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.		
HIT Product Name	Millennium Power Chart	Wellcentive	ECW
HIT Vendor	Cerner	Phillips	eClinicalWorks

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	N/A	N/A
Behavioral Health Counselor	N/A	1
Billing/Accounting Support	N/A	N/A
Care Managers - RNs	N/A	N/A
Care Managers - Medical Assistants	N/A	4
Care Managers - Other	N/A	N/A
Community Health Workers	N/A	4
Data Analysts	N/A	4
Health IT Support	N/A	2
Licensed Social Workers	N/A	2
Nutritionist	N/A	2
Pharmacists	N/A	2
Practice Transformation	N/A	1
Consultants		
Psychiatrist	N/A	2
Psychologist	N/A	2
Other	N/A	N/A

Vision

The One Health Quality CTO vision of how to assist practices achieve advanced primary care practice status is rooted in the principles of integration and coordination between clinical care practitioners, patients and community service providers. The vision of the One Health Quality CTO is to build team-based capabilities in primary care practices that will allow them to improve outcomes, reduce the total cost of care and optimize the patient experience. These capabilities include coordination of evidence-based clinical, psychological and social services interventions focusing on prevention, early treatment and communication among entities. The redesign of the primary care model will result in high quality, patient centered care and reduce the use of unnecessary services. The vision of the One Health Quality CTO stems from the century old tradition of Adventist HealthCare, its sponsoring organization. Adventist HealthCare has a long history of partnering with patients, providers and community services to promote health, prevent disease, address health disparities and improve outcomes by addressing patient needs in a broad context encompassing clinical and social determinants of health. The One Health Quality CTO sees itself as an integrator of providers and healthcare services organizations and patients. Engaging patients is a key to population health success but engagement of primary care providers is an essential factor in optimizing patient outcomes. One Health Quality CTO's vision is based on using connectivity support in all forms to unlock advances in population health management ultimately to transform health of individuals and communities. The One Health Quality CTO focuses on several interconnected strategies to achieve the practice transformation vision: technology advances to gather the required clinical and social determinant information; chronic disease detection, prevention & management; health & wellness education; quality clinical care, care management and care transitions support; patient experience optimization training. Briefly, One Heath Quality CTO uses a powerful data analytics platform to aggregate and normalize clinical data from multiple sources, risk-stratify the data and provide practices with actionable information based on quality metrics, risk scoring and gaps in care. The One Health Quality CTO has an associated community health and wellness division which provides community based health education programs and wellness activities. The One Health Quality CTO also participates in clinical pathway development and implementation for chronic disease conditions across the care continuum. The Care Transitions and Care Management division of the CTO is a robust system that provides post-acute care management, home visits, telemonitoring, strong behavioral health support, social services support and nursing education to patients transitioning between sites of care and for high risk chronic condition patients. Finally, the CTO has a performance improvement program based on the principles of Lean Six Sigma that can be deployed to improve processes and optimize clinical workflows. In sum, the goal of One Health Quality CTO is to support primary care practices to improve patient outcomes at the individual and population level, provide cost effective care and create an optimized experience for patients. The CTO is focused on helping practices engage patients by identifying high risk patients and gaps in care, focusing on coordination of services, facilitating communication channels and improving access. The One Health Quality CTO helps engage practices with the community by using proactive clinical care pathways, focusing on wellness and acting as a community resource navigator. Finally, the CTO focuses on helping practices reduce the Total Cost of Care by improved coordination, using technology, improving screening and avoiding duplication through enhanced connectivity and collaboration.

Approach to Care Delivery Transformation

Care Coordination: The CTO will form a Care Coordination team composed of care management RNs, community health workers, licensed clinical social workers, home health staff, certified diabetes educators, health educators and behavioral health providers. This interdisciplinary team will be focused on the empaneled beneficiaries of the practices and provide complementary support in terms of care delivery, education, social services assessments/deployment, assessment of the home environment, medication reconciliation, sequencing referrals to specialists and follow up to ensure data transfer and coordination. Care Transition Support: There will be access to a 24-hour care management service which will access the patient information through our data analytics platform Wellcentive. This team will support the practices with an array of transitions services according to the patient need. Standardized Beneficiary Screening: The CTO's data analytics platform uses the Johns Hopkins ACG risk profile program to use clinical data to risk score each patient based on resource utilization scoring, frailty flagging, and risk of hospitalization. The CTO will work with its practices to interface the practices' EMR data and any Medicare Claims data into the Wellcentive engine and produce real time risk scoring which will alert the practice to high need patients and produce actionable information for the practice. Data Tools and Informatics: The CTO is part of the Adventist IT infrastructure which not only includes two-way connectivity to CRISP but also its own certified HIE as well as a connection to Common well. Practice Transformation Assistance: The DMAIC process is based Lean Six Sigma principles to help achieve high quality, safe, and efficient care. This program allows for a consistent and structured process for practices to ensure clinical transformation and participate as teams in continuous improvement.